

# The Relationship of Trauma Exposure to Sex Offending Behavior Among Male Juvenile Offenders

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**ABSTRACT.** The most common type of adult and juvenile sex offender treatment utilizes a Relapse Prevention (RP) model. In RP clients learn about their offense cycle with an emphasis on recognizing high-risk situations and negative emotional states that can be precursors or triggers to offending behavior. This study identifies ways that traumatic experiences and trauma-associated feelings can be offense triggers for juvenile sex offenders. Researchers interviewed the treating clinicians of 40 male juvenile sex offenders who received at least six months of RP sex offender treatment. Results showed that 95% of the youths had experienced a Post Traumatic Stress Disorder (PTSD) Criterion A traumatic event and that 65% met criteria for PTSD based on clinician judgments. Overall, clinicians identified prior trauma exposure as being related to the offense triggers in 85% of offenders. Specifically, the following trauma-related feelings were identified as offense triggers: intense fear in 37.5% of sex offenders, helplessness in 55%, and horror in 20%. Implications for sex offender treatment programs are discussed. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <getinfo@haworthpressinc.com> Website: <<http://www.HaworthPress.com>> © 2002 by The Haworth Press, Inc. All rights reserved.]*

**KEYWORDS.** Sex offenders, juveniles, delinquency, trauma, offense cycle, offense triggers

### ***SEX OFFENDER TREATMENT***

Sex offenders have been considered poor candidates for treatment because of their social skills deficits, limited empathy, difficulty with forming a therapeutic relationship, and their frequent lack of a dystonic response to their offending behavior (Groth & Birnbaum, 1979; Knopp, 1984). Freud acknowledged these difficulties stating

Perverse sexuality is as a rule exceedingly concentrated, its whole activity is directed to one—and mostly to only one—aim; one particular component-impulse is supreme; it is either the only one discernible or it has subjected the others to its own purposes. (1924, p. 332)

White (1964) noted the difficulty of engaging a sex offender in therapy: "Even when they are young, the nature of their deviation injures

the constructive forces, especially the capacity for human relationships, on which successful therapy depends" (p. 383). Later theorists saw individual treatment as being counter productive for many sex offenders by replicating the dynamics of the sexual assault where the individual therapist may be manipulated and the denial maintained (Schwartz & Cellini, 1995).

The majority of sex-offender-specific treatment programs utilize a relapse prevention (RP) approach (Laws, 1989, 1995, 1999; Laws, Hudson, & Ward, 2000). Drawing on addiction behavior models and treatment modalities, RP recognizes treating sex offending behavior, like substance dependence, requires a comprehensive lifestyle change, a strong support network, and recognition of the possibility of relapse. RP treatment is "a self-control program designed to teach individuals who are trying to change their behavior how to anticipate and cope with the problem of relapse" (George & Marlatt, 1989, p. 2). Sex offender RP treatment programs generally include a range of group based cognitive-behavioral interventions including: psycho-education focused on the offense cycle, examination of offending behavior and history to recognize offense precursors, coping skill development, social skill training, aggression management, empathy training, and substance abuse treatment.

Most RP treatment approaches utilize a behavior cycle model to describe relapse. With regards to the offense cycle, Gray and Pithers (1993) describe a sequence of precursors involving "Unpleasant Affect > Deviant Fantasy > Passive Planning > Cognitive Distortion > Disinhibition > Deviant Act" (p. 298). If unchecked, the offense cycle can develop an addictive quality, reinforced through sexual gratification, and culminate in offending behavior (Bays & Freeman-Longo, 1989; Eldridge, 1998; Gray & Pithers, 1993; Way & Balthazor, 1990). Gray and Pithers (1993) also describe three types of offense risk factors:

- predisposing factors are those that occur either in early development or early in the abuser's sequence;
- precipitating factors are those that occur just prior to the offending and determine the type of offending behavior that is displayed;
- perpetuating factors are those that sustain the behavior into the future.

Most sex offender interventions aim first at the predisposing and/or precipitating risk factors (e.g., Knopp, 1984), also referred to as triggers, to stop a cycle before it leads to sexual acts that reinforce the sequence.

Optimally, offenders learn how to identify triggers and high-risk situations and how to manage them prior in order to prevent recourse to active deviant fantasy.

Pithers, Cumming, Beal, Young, and Turner (1989) examined early and immediate offense precursors among 200 male sex offenders treated at the Vermont Treatment Center for Sexual Aggressors. Treating clinicians reviewed records to identify risk factors related to each subject's offense. The sample was divided into rapists ( $N = 64$ ) and pedophiles ( $N = 136$ ).

Common early precursors seen at over a 40% rate for both rapists and pedophiles included: family chaos, parental marital discord, and parental absence/neglect. Common risk factors that the offenders experienced just prior to the offense at over a 40% rate were: cognitive distortions, disordered sexual arousal pattern, emotional inhibition or over-control, low self-esteem, low victim empathy, sexual knowledge deficit, and social skills deficits. Of the 10 common early and immediate precursors to sexual aggression listed above, 6 may either directly or indirectly relate to early trauma exposure: family chaos, parental marital discord, paternal absence/neglect, emotional inhibition or over-control, low self-esteem, and social skills deficits. Additionally, of the 17 other risk factors seen at over a 40% rate for either rapists or pedophiles, many were directly related to trauma exposure (e.g., maternal absence/neglect, physical abuse as a child, and sexual victimization prior to age 12).

### ***TRAUMA EXPOSURE AND DELINQUENCY***

Recent studies have documented the high incidence of trauma exposure among juvenile offenders. These exposures include childhood physical and/or sexual abuse (Cauffman, Feldman, Waterman, & Steiner, 1998; Smith & Thornberry, 1995; Weeks & Widom, 1998; Widom, 1995); experiencing serious life threats and/or injuries (Burton, Foy, Bwanausi, Johnson, & Moore, 1994; McMackin, Morrissey, Newman, Erwin, & Daly, 1998); witnessing severe injury and/or death of another (Burton et al., 1994; Cauffman et al., 1998; McMackin et al., 1998; Steiner, Garcia, & Matthews, 1997); and being involved in gang violence (Burton et al., 1994; McMackin et al., 1998; Steiner et al., 1997). The typical juvenile offender has been exposed to numerous potentially traumatic events and is likely to have a correspondingly high risk of developing Posttraumatic Stress Disorder (PTSD).

PTSD is defined in the *Diagnostic and Statistical Manual IV (DSM IV)*; American Psychiatric Association, 1994) as an anxiety disorder resulting from exposure to one or more traumatic events. The traumatic event(s) must involve actual or threatened injury to oneself or others, and engender concomitant feelings of fear, helplessness, or horror. Developmentally inappropriate childhood experiences, such as sexual abuse that does not necessarily involve self-identified feelings of fear, horror, and helplessness, but lead to disorganized and agitated behavior are also considered as qualifying traumatic events. Events that meet these definitions meet the Criterion A specification for PTSD. Exposure to a Criterion A event is necessary, but not by itself, a sufficient condition, for the diagnosis of PTSD. Three other Criteria (B, re-experiencing the trauma; C, avoidance/numbing; D, increased arousal) must be present for at least 30 days (Criterion E) and cause great distress or impairment in functioning (Criterion F) in order to meet full diagnostic requirements. Table 1 outlines the diagnostic criteria for PTSD as found in the *DSM IV* (American Psychiatric Association, 1994).

The severity and number of trauma exposures seen in a delinquent population, combined with their psychological and developmental vulnerabilities and their lack of protective factors, place them at high risk for developing PTSD. Prevalence rates for a diagnosis of current PTSD in male juvenile offenders have been found to range from 17% to 32% (Burton et al., 1994; McMackin et al., 1998; Steiner et al., 1997) and to be as high as 49% among female juvenile offenders (Cauffman et al., 1998). Although PTSD rates are not available for juvenile or adult sex offenders, that many offenders have traumatic life histories has long been known. Typologies of sex offenders refer to some offender types as "reenactment trauma" (Rasmussen, Burton, & Christopherson, 1990), "sexually reactive" (Gil & Johnson, 1993), and "trauma-induced reactions" (Gray & Pithers, 1993).

This study was designed to examine the relationship of previous trauma exposure and its associated sequelae to the sex offenders' offense cycle. It was hypothesized that there would be a direct relationship between the offender's triggers and the emotional reactions of fear, horror and helplessness that are associated with a Criterion A traumatic event.

TABLE 1. *DSM IV* Criteria for Diagnosing Post-Traumatic Stress Disorder

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<b>A. Presence of Qualifying Traumatic event (<i>both needed</i>)</b>	
(1)	actual or threatened death or serious injury to self or others. (In children inappropriate developmental experience.)
(2)	the person's response involved intense fear, helplessness, or horror. (In children, disorganized or agitated behavior qualifies.)
<b>B. Re-experiencing symptoms (<i>1 symptom needed</i>)</b>	
(1)	intrusive recollections
(2)	distressing dreams
(3)	acting or feeling as if event were recurring
(4)	psychological distress at exposure to event-related cues
(5)	physiological reactivity on exposure to event-related cues
<b>C. Avoidance and numbing symptoms (<i>2 symptoms needed</i>)</b>	
(1)	avoidance of event-related thoughts, feelings, or conversations
(2)	avoidance of event-related activities, places, or people
(3)	inability to recall important aspect of event
(4)	diminished interest or participation in activities
(5)	detachment or estrangement
(6)	restricted range of affect
(7)	sense of a foreshortened future
<b>D. Hyperarousal symptoms (<i>2 symptoms needed</i>)</b>	
(1)	difficulty falling or staying asleep
(2)	irritability or outbursts of anger
(3)	difficulty concentrating
(4)	hypervigilance
(5)	exaggerated startle response
<b>E. Duration of disturbance at least one month</b>	
<b>F. Significant distress or impairment in functioning</b>	

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## METHODS

Eight clinicians were interviewed at six different residential treatment programs operated by or under contract to the Massachusetts Department of Youth Services (DYS). Three facilities were secure treatment programs, which are the highest level of secure juvenile programming offered in the state. The other three facilities were community-based residences where youths are placed prior to return to their home community.

Each program employed a Relapse Prevention component for sex offender treatment and maintained a detailed client record that contained police reports, arrest history, case history, evaluative material, progress notes, patient treatment homework assignments, and school material.

There were five inclusion criteria for juvenile offender records reviewed in this study:

1. The youth was male;
2. The youth had to have been in a program that offered sex offender specific treatment groups with a RP component for at least six months;
3. The youth acknowledged his offense;
4. The youth identified offense cycle triggers;
5. The clinician was either the youth's primary individual therapist or group therapist for sex offender issues.

The clinicians were asked to randomly select clients from their current or prior caseload that met the inclusion criteria. Clinicians drew from their current caseload and records stored on their units. No specific provisions, other than initial instructions, were included to ensure the randomness of record selection. Youth were identified by first names to the study data collectors who did not have direct access to the records. Birth dates were cross-checked to ensure no youth's record was reviewed twice due to transfer between units.

Once a subject was identified, the treating clinician was interviewed regarding the youth's offense history to determine if the youth had been adjudicated delinquent of a sex offense or had other violent crimes. A brief educational, substance abuse, family, and psychiatric history was taken. The clinician was then queried regarding the youth's exposure to eight types of trauma: physical abuse, witnessing physical abuse, victim of other violence, sexual abuse, witnessing sexual abuse, being in a serious accident or disaster, witnessing a sudden or violent death, and other trauma. When a history of trauma was found, the extent of the exposure was determined and if the youth experienced either intense fear, horror or helplessness associated with the trauma.

To determine a PTSD diagnosis associated with trauma histories, clinicians identified up to three traumatic exposures that had the greatest impact on the youth (Criterion A events). Clinicians were then queried regarding each symptom associated with the PTSD diagnosis in the *DSM IV* in relation to the Criterion A event(s). A PTSD diagnosis was made based on symptoms endorsed by the treating clinician.

The youths selected by the clinicians were not contrasted with other sample populations so no tests of statistical significance were used to contrast their PTSD rate to those of other juvenile or adult offender populations.

To connect the youth's trauma exposure(s) to his offense cycle, the clinicians were asked if any of the youth's triggers were intense feelings of fear, helplessness, or horror. If yes, the clinicians then determined

which event(s) these feelings were associated with in order to ascertain if there was a trauma link. Clinicians were also asked if they saw any of the youth's triggers related to re-experiencing traumatic events or feeling associated to re-experiencing of earlier traumatic events and, if yes, to which events. Finally, the clinicians were asked if they saw any association between the youth's offense cycle and his traumatic experience.

Each clinician interview took 20 to 30 minutes. During the interview the clinicians had access to the complete client record in order to refresh their memories and check answers.

### **PARTICIPANTS**

The clinician sample had a mean age of 35.4 years, had been in clinical practice an average of 11.9 years, and spent an average of 6.4 years working with sex offenders. Clinicians were all white with 50% male and 50% female. All held either a master's or doctoral degree in psychology or social work.

Forty juvenile, male sex offenders met the inclusion criteria and were selected for the study by the treating clinicians. In Massachusetts, individuals under age 17 are considered juveniles and are involved in the juvenile courts. At age 17 they become part of the adult court system. Race of the offenders was 57.5% White, 17.5% Hispanic, 15% African-American, 2.5% Asian, and 7.5% Bi-racial. Racial characteristics varied somewhat from those of the general DYS population that are 44% White, 25% Hispanic, 23% African-American, 3% Asian, and 5% Other (Sylva, 1999). At the time of their first commitment to DYS, participants ranged in age from 12 to 17 with a mean of 14.1 years old ( $SD = 1.1$ ), which is younger than the mean age of first commitment for other DYS youth, 15.2 years (Sylva, 1999). Their length of time in treatment ranged from 6 to 30 months with a mean of 13.9 months ( $SD = 5.21$ ).

All youth had a history of sex offending. While 80% had been adjudicated delinquent of a sex crime(s), the remaining 20% had either pleaded down their offense (e.g., from indecent assault and battery to assault and battery), or had a sex offense history that was uncovered either while they were in DYS placement for another offense or through the Department of Social Services (DSS). Table 2 presents the offense types for the full sample, both those adjudicated and not adjudicated of a sex offense.

Forty percent of the youth had been convicted of another non-sex offense violent crime, and 62.5% had a history of other violent behavior.

TABLE 2. Sex Offense Type (N = 40)

Offense Category	Offense Rate	Convicted	Not Convicted	Total
Rape of a Child	35.0%	12	2	14
Rape	12.5%	3	2	5
Indecent Assault & Battery Child	22.5%	6	3	9
Indecent Assault & Battery	25.0%	10	-	10
Indecent Exposure	2.5%	1	-	1
Voyeurism	2.5%	-	1	1
Total	100.0%	32	8	40

Offenses were committed individually by 82.5%, in a group by 12.5%, and both individually and in a group by 5%; 37.5% were under the influence of drugs or alcohol at the time of their offense. Clinicians saw 27.5% of the youth as having an alcohol problem and 50% as having a drug problem. Psychotropic medications were taken by 25% while in placement and 17.5% had a history of psychiatric hospitalizations.

Most youth came from multi-problem homes with 52.5% raised primarily by their mother, 5% by their father, 27.5% by both parents and 15% by neither parent. Mothers regularly visited 57.5% of youth while in placement, but only 20% received regular visits from their fathers. The child welfare system (DSS) had been involved with 42.5% prior to the juvenile justice system.

Grade level prior to placement ranged from the 7th to the 11th grade with a mean of 8.4. School problems were reported by 72.5% of youth and 57.5% had received Special Education services in public school.

## RESULTS

Some type of trauma exposure was reported for 95% of the sample by the treating clinician. Table 3 displays the trauma exposure by category, mean age of first exposure, and mean number of trauma exposures.

The incidence rates for the number of trauma exposures for categories related to the experience or witnessing of physical or sexual abuse were difficult to establish. For example, in response to the question regarding a youth's frequency of exposure to physical abuse a clinician may indicate at least twice weekly from age 1 to 10 with a potential total of over 1000 incidents. Clinicians were asked to estimate the total number of exposures to the best of their ability based on their knowledge of

TABLE 3. Trauma Exposure Rates, Mean Age of First Exposure, and Mean Number of Exposures (N = 40)

Trauma Category	Exposure Rate	Age First Exposure	SD	Number of Exposures	SD
Physically Abused	80%	4.6	4.4	> 100	N/A
Witness Family Physical Abuse	62.5%	3.3	3.3	> 100	N/A
Other Violent Victimization	50%	10.3	3.8	28.0	54.4
Sexually Abused	56%	7.0	4.2	> 100	N/A
Witness Family Sexual Abuse	13%	9.5	3.3	> 100	N/A
In Serious Accident/ Disaster	6%	14.0	2.8	1.5	0.8
Experience Unexpected or Violent Death	31%	11.6	1.1	1.4	0.8
Other Trauma	28%	10.4	3.7	1.0	0.0

the youth and the existing record. The extent of the abuse history along with its early onset also made it difficult to establish which incident had the greatest impact on a youth and in such cases the cumulative history of abuse was accepted as the most significant event.

The record review and clinician interview indicated only 12.5% of the youth had no direct exposure to either physical or sexual abuse, while 47.5% of the youth were exposed to both physical and sexual abuse. Physical abuse, sexual abuse and other violent victimization was experienced by 27.5% of the sample and 77.5% experienced exposure from 3 or more trauma categories.

Table 4 displays the three Criterion A events that had the greatest effect on the youth as identified by treating clinicians. Experiencing or witnessing physical abuse was identified as the most significant traumatic event for 50% of the youth.

The rate of PTSD among these juvenile sex offenders based on endorsement of symptoms by their treating clinicians was 65%. Rates of PTSD for the subsets of offenders with histories of abuse were: 86.4% ( $N = 22$ ) for those with sexual abuse history; 68.8% ( $N = 32$ ) for those with physical abuse history; and 84% ( $N = 19$ ) for those with both physical and sexual abuse history. There was a 100% rate of PTSD for the offenders with histories of physical abuse, sexual abuse, and being a victim of other violence ( $N = 11$ ).

TABLE 4. Criterion A Events That Had the Greatest Impact (N = 40)

Trauma Category	Greatest Impact	Second Greatest Impact	Third Greatest Impact
Physical Abuse	42.5%	17.5%	5.0%
Witness Physical Abuse	7.5%	20.0%	7.5%
Victim of Violence	5.0%	7.5%	2.5%
Sexual Abuse	22.5%	12.5%	7.5%
Witness Sexual Abuse	--	2.5%	5.0%
In Serious Accident/Disaster	--	--	2.5%
Experience Unexpected or Violent Death	7.5%	5.0%	2.5%
Other Trauma	7.5%	12.5%	10.0%
No Event	7.5%	22.5%	57.5%
Total	100%	100%	100%

Overall, clinicians saw a sex offender's trauma history being related to his offense cycle in 85% of the youth. In 62.5% of the sample ( $N = 25$ ), they identified the specific feelings of fear, horror and/or helplessness as related to an offender's offense trigger. Those feelings were seen as directly related to a youth's trauma experience in 96% ( $N = 24$ ) of the offenders. Table 5 presents the rates of trauma associated feelings of fear, helplessness, and/or horror to offense triggers.

The experience of trauma associated helplessness related to a youth's offense trigger was seen in 55% of the full sample. Among the youth with histories of physical abuse, 68.7% had helplessness identified as an offense trigger. Among the youth with sexual abuse histories, 72.7% had helplessness identified as an offense trigger. Among the youth with both physical and sexual abuse histories, 78.9% had helplessness identified as a trigger.

## DISCUSSION

The very high prevalence of trauma exposure among the juvenile sex offenders in this study is consistent with earlier findings regarding trauma exposure among juvenile offenders (Burton et al., 1994; McMackin et al., 1998; Steiner et al., 1997). This study determined a 95% rate of trauma exposure among juvenile sex offenders, with 77.5% of youth exposed to trauma from three or more categories. Physical or

TABLE 5. Feelings of Fear, Helplessness and/or Horror Related to Offense Cycle Triggers\*

Offense Trigger	Number	Percent
Fear—Trauma related	15	37.5%
Fear—Not trauma related	1	2.5%
Helplessness—Trauma related	22	55.0%
Helplessness—Not trauma related	2	5.0%
Horror—Trauma related	8	20.0%
Horror—Not trauma related	1	2.5%
Offense trigger not related to fear, helplessness and/or horror	15	37.5%

\*Percentages add up to over 100% due to many offenders having multiple triggers

sexual abuse was seen in all but 12.5% of the sample, with 47.5% exposed to both. The mean age of onset for physical abuse was 4.6 years and 7.0 years for sexual abuse.

The overall rate of PTSD was 65%. The rate was 68% for juvenile sex offenders with a history of physical abuse, 84% for individuals with histories of both physical and sexual abuse and 100% for individuals with abuse histories who were also victims of other violence. The increasing rates of PTSD for youth with exposures from multiple trauma categories supports recognition that exposure to multiple traumas has a synergistic impact (Kiser, Heston, Millsap & Pruitt, 1991).

The PTSD rates reported here are higher than any other published data for juvenile offender populations (Burton et al., 1994; McMackin et al., 1998; Steiner et al., 1997). The offenders with the trauma exposures from multiple trauma categories were those identified with the highest rates of PTSD. The multiple trauma exposures, early onset of trauma exposure, and lack of familial support as a protective factor (evidenced by a physical abuse rate of 80%) can help account for the high PTSD rate.

Most significant in respect to criminal behavior is the clinician-identified link of the trauma-associated affects of fear, helplessness and horror to a youth's sex offense cycle. The concept that an individual is accountable for his or her actions is central to all offender treatment models. Juvenile Justice professionals are sensitive to not providing excuses to offenders for their behavior, which may contribute to not focusing on how closely trauma is entwined within the offense cycle. Our findings suggest a close relationship between trauma and offense cycle

triggers. Dealing with trauma-associated feelings and experiences may be an important target for sex offender treatment to successfully decrease the risk of re-offending.

The need for understanding the link between trauma exposure and offender behavior is underscored by a recent survey of sex offender therapists conducted by three of the present authors at the 2000 Joint Regional Conference of The Massachusetts Sex Offender Coalition and The Massachusetts Association For The Treatment of Sexual Abusers (McMackin, Cusack & LaFratta, 2001). This survey found that therapists that worked with youthful offenders ( $N = 59$ ) estimated the patient PTSD rate to be 56%, with 77% having histories of physical abuse, 68% sexual abuse, and 65% both. The therapist reported only 26% of their patients received trauma-focused group treatment.

Metaphorically, the offense cycle may drive the behavior as an engine drives a car but trauma associated feelings, particularly those of helplessness and fear, can be similar to the starter motor that initially engages the engine. The starter could never drive 2000 pounds of steel but it is strong enough to engage the engine that will. Trauma treatment should be more of a priority in sex offender treatment to enhance clinical effectiveness and public safety.

Specific ways in which trauma treatment could be integrated into sex offender treatment include

- Training sex offender therapists in understanding the close link between trauma and sex offending triggers;
- Screening all sex offenders for trauma histories;
- Assessing sex offenders for the presence of PTSD as a co-morbid condition;
- Having sex offenders diagnosed with PTSD and/or with histories of trauma exposure participate in a trauma focused treatment group that is integrated into their overall RP offender treatment plan;
- Teaching sex offenders how to better manage trauma associated affects, especially helplessness and fear.

## ***LIMITATIONS***

The findings of this study are striking, particularly with respect to the high rate of PTSD and trauma exposure among sex offenders, and the relationship of that trauma exposure and associated sequelae to the of-

fense cycle. However it should be remembered that all data regarding trauma exposure were based on the clinicians' judgement aided by their access to the clients' records. A structured interview format was used to give clinicians as many specific questions and points of reference as possible; nevertheless, a study using direct assessment techniques of the offenders themselves would strengthen the evidence.

Additionally, all youth referred to in this study were adjudicated delinquent. Many youth who engage in sexually inappropriate behavior do not get adjudicated delinquent and are referred to a child welfare agency rather than the courts and it is uncertain if their trauma histories would be similar to those adjudicated delinquent. It is also uncertain if the juvenile population in Massachusetts is similar to offender populations in other states.

It should be noted that many subjects had histories of profound physical and sexual abuse, which included hundreds of incidents. At times clinicians could not determine which of those events had the greatest impact on the subject; thus, a specific *DSM IV* Criterion A event could not be determined. Many of the offenders whose records were reviewed could have met the diagnosis of Type II PTSD as defined by Terr (1991) or Complex PTSD as defined by Herman (1992). Although these diagnoses are not accepted by the American Psychiatric Association in the *DSM IV* (1994), additional consideration needs to be given to the impact of profound and long-term abuse on criminal behavior.

## CONCLUSION

Proper treatment of sex offenders, particularly at a young age, can enhance public safety and reduce the human suffering that the offender experiences and inflicts on others. A prospective treatment study should be considered to determine the extent to which addressing trauma-related triggers improves treatment outcome.

Finally, it must be remembered that sex offending is a violent crime. Other violent offenders also have histories of significant trauma exposure. Offense patterns for violent offenders should be examined to see if trauma-associated affects can act as precursors for other violent offenders.

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